		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040956

Facility Name: THE WEALSHIRE

Address: 150 JAMESTOWN LANE (Number) LINCOLNSHIRE (City) 60069 (Zip Code)

County: LAKE

Telephone Number: (847) 883-9000 **Fax #** (847) 883-9029

IDPA ID Number: 363952069001

Date of Initial License for Current Owners: 08/15/95

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) ARNOLD GOLDBERG
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 08/27/03

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	68	Skilled (SNF)	90	27,614	1
2		Skilled Pediatric (SNF/PED)			2
3	64	Intermediate (ICF)	42	20,566	3
4		Intermediate/DD			4
5	12	Sheltered Care (SC)	12	4,380	5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,560	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		26,917	3,906	30,823	8
9	SNF/PED					9
10	ICF	1,004			1,004	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	1,004	26,917	3,906	31,827	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.55%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
DAYCARE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/14/95

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/14/95 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 44 and days of care provided 3,906

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	197,595	23,918	6,341	227,854		227,854		227,854			1
2	Food Purchase		196,826		196,826	(13,315)	183,511		183,511			2
3	Housekeeping	315,932	29,269		345,201		345,201		345,201			3
4	Laundry	81,001	14,108		95,109		95,109		95,109			4
5	Heat and Other Utilities			155,734	155,734		155,734		155,734			5
6	Maintenance	103,207	10,775	112,627	226,609		226,609	36,040	262,649			6
7	Other (specify):*			9,276	9,276		9,276		9,276			7
8	**TOTAL General Services**	697,735	274,896	283,978	1,256,609	(13,315)	1,243,294	36,040	1,279,334			8
	B. Health Care and Programs											
9	Medical Director			20,050	20,050		20,050		20,050			9
10	Nursing and Medical Records	2,687,651	96,588	5,478	2,789,717		2,789,717		2,789,717			10
10a	Therapy		8,012		8,012		8,012		8,012			10a
11	Activities	222,871	19,239	756	242,866		242,866		242,866			11
12	Social Services	82,908			82,908		82,908		82,908			12
13	Nurse Aide Training											13
14	Program Transportation			5,047	5,047		5,047		5,047			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,993,430	123,839	31,331	3,148,600		3,148,600		3,148,600			16
	C. General Administration											
17	Administrative	74,339		379,200	453,539		453,539	(264,200)	189,339			17
18	Directors Fees											18
19	Professional Services			161,301	161,301		161,301	3,120	164,421			19
20	Dues, Fees, Subscriptions & Promotions			221,921	221,921		221,921	(187,326)	34,595			20
21	Clerical & General Office Expenses	377,064	43,891	91,318	512,273		512,273	(73,615)	438,658			21
22	Employee Benefits & Payroll Taxes			771,817	771,817	13,315	785,132		785,132			22
23	Inservice Training & Education			3,066	3,066		3,066		3,066			23
24	Travel and Seminar			6,043	6,043		6,043		6,043			24
25	Other Admin. Staff Transportation			8,283	8,283		8,283		8,283			25
26	Insurance-Prop.Liab.Malpractice			5,725	5,725		5,725	107,544	113,269			26
27	Other (specify):*											27
28	**TOTAL General Administration**	451,403	43,891	1,648,674	2,143,968	13,315	2,157,283	(414,477)	1,742,806			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,142,568	442,626	1,963,983	6,549,177		6,549,177	(378,437)	6,170,740			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: THE WEALSHIRE **#0040956** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,341	
	REPAIRS & MAINTENANCE		0	
			0	6,341
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		36,569	
	ELECTRICITY		86,771	
	WATER		32,394	
	CABLE TV - LOBBY		0	
			0	155,734
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		17,597	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		64,540	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		6,995	
	ELEVATOR MAINTENANCE & REPAIR		5,938	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,237	
	FIRE SERVICE		0	
	CONTRACTED BUILDING MAINTENANCE		15,320	
			0	
			0	112,627
7	**OTHER**			
	SCAVENGER		8,898	
	SECURITY SERVICE		378	9,276
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	20,050	20,050

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	744	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	1,045	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	963	
	PHARMACY CONSULTANT	XVIII B 39-2	2,726	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	5,478
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	756	
			0	756
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number THE WEALSHIRE **#0040956** **Report Period Beginning: 01/01/2003** **Ending: 12/31/2003**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		5,047	5,047
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	379,200	379,200
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	3,027	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	158,274	
			0	161,301
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	186,600	
	EMPLOYEE WANT ADS	XIX F	21,337	
	CONTRIBUTIONS	VI 20 XIX F	726	
	DUES & SUBSCRIPTIONS	XIX F	934	
	LICENSES & PERMITS	XIX F	4,705	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	7,061	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	558	221,921
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		52,883	
	OUTSIDE CLERICAL SERVICES			
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		37,464	
	MESSENGER SERVICE		971	
			0	91,318

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	317,951	
	UNEMPLOYMENT COMPENSATION	XIX D	45,045	
	WORKERS COMPENSATION INSURANCI	XIX D	164,612	
	HOSPITALIZATION INSURANCE	XIX D	241,137	
	EMPLOYEE BENEFITS - OTHER	XIX D	3,072	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	771,817
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		3,066	3,066
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	6,043	
			0	
			0	6,043
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		8,283	8,283
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		5,725	5,725
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,963,983

Facility Name & ID Number THE WEALSHIRE #0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			45,176	45,176		45,176	1,178,439	1,223,615			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			12,995	12,995		12,995	1,316,888	1,329,883			32
33	Real Estate Taxes							125,269	125,269			33
34	Rent-Facility & Grounds			1,794,400	1,794,400		1,794,400	(1,794,400)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,852,571	1,852,571		1,852,571	826,196	2,678,767			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		104,220	332,760	436,980		436,980		436,980			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			72,270	72,270		72,270		72,270			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		104,220	405,030	509,250		509,250		509,250			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,142,568	546,846	4,221,584	8,910,998		8,910,998	447,759	9,358,757			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	428,300	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(726)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(186,600)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(337,247)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (96,273)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	544,032		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 544,032		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 447,759		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

THE WEALSHIRE

ID# 0040956

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 5,834	6	1
2	MARKETING SALARIES	(78,881)	21	2
3	ADJ MANAGEMENT FEES	(264,200)	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(337,247)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	5,834	30,206	0	0	0	0	0	0	0	0	0	36,040	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	5,834	30,206	0	0	0	0	0	0	0	0	0	36,040	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(264,200)	0	0	0	0	0	0	0	0	0	0	(264,200)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,120	0	0	0	0	0	0	0	0	0	3,120	19
20	Fees, Subscriptions & Promotions	(187,326)	0	0	0	0	0	0	0	0	0	0	(187,326)	20
21	Clerical & General Office Expenses	(78,881)	5,266	0	0	0	0	0	0	0	0	0	(73,615)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	107,544	0	0	0	0	0	0	0	0	0	107,544	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(530,407)	115,930	0	0	0	0	0	0	0	0	0	(414,477)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(524,573)	146,136	0	0	0	0	0	0	0	0	0	(378,437)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number THE WEALSHIRE # 0040956 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	428,300	750,139	0	0	0	0	0	0	0	0	0	1,178,439	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	1,316,888	0	0	0	0	0	0	0	0	0	1,316,888	32
33	Real Estate Taxes	0	125,269	0	0	0	0	0	0	0	0	0	125,269	33
34	Rent-Facility & Grounds	0	(1,794,400)	0	0	0	0	0	0	0	0	0	(1,794,400)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	428,300	397,896	0	0	0	0	0	0	0	0	0	826,196	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(96,273)	544,032	0	0	0	0	0	0	0	0	0	447,759	45

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ARNOLD GOLDBERG	99	THE PONDS OF WEALSHIRE	LINCOLNSHIRE	LINCOLNSHIRE PR	LINCOLNSHIRE	BLDG PSHP
THE WEALSHIRE INC	1	THE OAKS OF BURR RIDGE	BURR RIDGE	ALEXANDER BLAKI	SKOKIE	MGMT CO

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT INCOME	$ 1,794,400	LINCOLNSHIRE PROPERTIES, L.P.		$	$ (1,794,400)	1
2	V	19	ACCOUNTING FEES		" "		3,120	3,120	2
3	V	26	INSURANCE		" "		107,544	107,544	3
4	V	32	MORTGAGE INTEREST		" "		1,316,888	1,316,888	4
5	V	21	OFFICE EXPENSES		" "		5,266	5,266	5
6	V	6	MAINTENANCE		" "		30,206	30,206	6
7	V	33	REAL ESTATE TAXES		" "		125,269	125,269	7
8	V	30	SL DEPRECIATION		" "		750,139	750,139	8
9	V				" "				9
10	V				" "				10
11	V				" "				11
12	V				" "				12
13	V				" "				13
14	Total			$ 1,794,400			$ 2,338,432	$ * 544,032	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD GOLDBERG	OWNER	ADMINISTRATIV	99.00	NONE	35	70.00	ALLOC MGT	$ 379,200	17-3	1
2		(ALEXANDER AND BLAKE)									2
3					LESS DISALLOWED ON PAGE 5A				(264,200)	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 115,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY-LINCOLNSHIRE PROPERTIES:						$	$			$	1
2	DIAWA FINANCE CORP		X	MORTGAGE	$129,285.00	10/31/97	16,000,000	14,311,432	10/31/07	8.1500	1,237,639	2
3			X	MORTGAGE LOAN FEES AMORTIZED OVER 10 YRS			593,987	227,693			59,399	3
4	ESTATE OF RUTH LIPSCHULTZ										19,850	4
5												5
	Working Capital											
6	1ST EQUITY		X	LINE OF CREDIT	DEMAND		250,000	249,629		5.7500	12,995	6
7												7
8												8
9	TOTAL Facility Related				$129,285.00		$ 16,843,987	$ 14,788,754			$ 1,329,883	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 16,843,987	$ 14,788,754			$ 1,329,883	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	118,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	121,564	2
3. Under or (over) accrual (line 2 minus line 1).	$	2,964	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	122,305	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	125,269	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	106,006	8
	1999	107,637	9
	2000	113,126	10
	2001	114,629	11
	2002	121,564	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2002 TAX BILL.-LINCOLNSHIRE PROPERTIES

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME THE WEALSHIRE COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0040956

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	15-15-200-062	NURSING HOME	$ 121,563.57	$ 121,563.57
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 121,563.57	$ 121,563.57

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1994	$ 970,925	1
2					2
3	TOTALS			$ 970,925	3

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	LINCOLNSHIRE PROPERTIES			1995	$ 11,521,031	$ 292,411	20	$ 576,052	$ 283,641	$ 4,824,435	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LINCOLNSHIRE PROPERTIES:										9
10	MUSIC SYSTEM			1999	33,003	1,650	20	1,650		6,944	10
11	SIDEWALK			1999	4,660	233	20	233		971	11
12	PATIO			2001	5,200	260	20	260		553	12
13	SIDEWALK			2001	2,325	116	20	116		247	13
14	CARPETING			2002	12,473	624	5	624		702	14
15	SPRINKLER SYSTEM			2002	6,805	340	20	340		439	15
16	REMODELLING			2003	20,650	301	20	301		301	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	LEASEHOLD IMPROVEMENTS	1995	$ 34,126	$	20	$ 1,706	$ 1,706	$ 13,976	37
38	LEASEHOLD IMPROVEMENTS	1996	4,059		20	203	203	1,516	38
39	LEASEHOLD IMPROVEMENTS	1998	3,993		20	399	399	2,128	39
40	ALARM SYSTEM	1999	9,183		20	459	459	1,963	40
41	SECURITY SYSTEM	1999	4,427		20	221	221	927	41
42	CABLING/WINDOWS/CABINETS/LUMBER/FIRE SAFETY/ETC	2000	23,775		20	1,189	1,189	4,261	42
43	SIGN	2000	1,611		20	81	81	277	43
44	BOILER WORK	2000	871		20	44	44	132	44
45	BEARING & ASSEMBLING	2001	1,136		20	57	57	152	45
46	PUMP W/MOTOR	2001	704		20	35	35	79	46
47	COMPRESSOR	2001	1,797		20	90	90	233	47
48	BOILER WORK	2001	1,722		20	86	86	251	48
49	BOILER WORK	2001	1,008		20	50	50	146	49
50	ROOF REPAIR	2001	500		20	25	25	60	50
51	PHONE SYSTEM	2001	1,713		20	86	86	251	51
52	BLACKTOP & PATCH	2001	4,799		20	240	240	720	52
53	CARPETING	2002	1,158		20	58	58	113	53
54	EXTERIOR DOORS	2002	9,700		20	485	485	536	54
55	BOILER REPAIRS	2002	8,124		20	406	406	812	55
56	SPRINKLER SYSTEM	2002	950		20	48	48	96	56
57	BLACKTOP REPAIR	2002	2,799		20	140	140	280	57
58	BOILER REPAIRS	2002	1,077		20	54	54	108	58
59	PUMP & BOILER REPAIRS	2002	3,376		20	169	169	338	59
60	FIRE SAFETY UPGRADES	2003	9,901		20	248	248	248	60
61	SEWAGE EJECTORS/DISPOSER/PUMP	2003	12,848		20	321	321	321	61
62	BORIS BARBARIC-PAINTING	2003	5,950		5	595	595	595	62
63	TELEPHONE LINES	2003	4,229		20	106	106	106	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 11,761,683	$ 295,935		$ 587,177	$ 291,242	$ 4,865,217	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,757,673	$ 45,176	$ 176,682	$ 131,506	10	$ 1,716,249	71
72	Current Year Purchases	48,892		2,652	2,652	8-15 YR	2,652	72
73	Fully Depreciated Assets	30,188					30,188	73
74	LINCOLNSHIRE PROPERTIES	257,875	22,441	22,441		3-15 YRS	111,332	74
75	TOTALS	$ 2,094,628	$ 67,617	$ 201,775	$ 134,158		$ 1,860,421	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		96 DODGE RAM	2001	$ 14,500	$	$ 2,900	$ 2,900		$ 6,767	76
77										77
78	LINCOLNSHIRE PROPERTIES:									78
79		PORSCHE	2000	56,313	5,631	5,631		10 YRS	14,078	79
80	TOTALS			$ 70,813	$ 5,631	$ 8,531	$ 2,900		$ 20,845	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,898,049	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 369,183	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 797,483	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 428,300	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,746,483	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	COMPLETION OF BLDG 1996	$ 58,161	$ 1,491	$ 11,245	86
87	LANDSCAPING	43,000	2,867	21,502	87
88	BUILDING 1997 SEC.754	4,482,861	107,320	666,312	88
89	DR.OFFICE - DEPRECIATION			3,000	89
90					90
91	TOTALS	$ 4,584,022	$ 111,678	$ 702,059	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ ____ Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATIVE	2002 FORD SABLE	$ 406.00	$ 6,172	17
18					18
19					19
20					20
21	TOTAL		$ 406.00	$ 6,172	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 160,234	$		$ 160,234	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			8,606			8,606	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			153,200			153,200	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				30,313		30,313	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MASSAGE & INHALATION THERAPY	39-3				10,720			10,720	
	Other (specify): LAB, RENTAL,SUPPI	39-2					73,907		73,907	13
14	TOTAL			$		$ 332,760	$ 104,220		$ 436,980	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (213,264)	$ (220,752)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	328,647	328,647	3
4	Supply Inventory (priced at)	33,554	33,554	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,659,255	2,079,731	8
9	Other(specify): RESERVES/ESCROWS		174,958	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,808,192	$ 2,396,138	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		3,190,356	13
14	Buildings, at Historical Cost		16,979,681	14
15	Leasehold Improvements, at Historical Cost	112,322	240,437	15
16	Equipment, at Historical Cost	432,184	746,372	16
17	Accumulated Depreciation (book methods)	(367,190)	(7,088,321)	17
18	Deferred Charges		227,693	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS		1,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 177,316	$ 14,297,218	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,985,508	$ 16,693,356	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,621,757	$ 1,664,097	26
27	Officer's Accounts Payable	3,293,500	3,293,500	27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	616,817	616,817	29
30	Accrued Salaries Payable	203,103	203,103	30
31	Accrued Taxes Payable (excluding real estate taxes)	73,066	73,066	31
32	Accrued Real Estate Taxes(Sch.IX-B)		122,305	32
33	Accrued Interest Payable		102,000	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 5,808,243	$ 6,074,888	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		14,593,809	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 14,593,809	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,808,243	$ 20,668,697	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,822,735)	$ (3,975,341)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,985,508	$ 16,693,356	48

*(See instructions.)

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (2,563,100)	1
2	Restatements (describe):		2
3			3
4	PRIOR YEAR ADJUSTMENT	196,738	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (2,366,362)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(1,456,373)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (1,456,373)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,822,735)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,180,806	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,180,806	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	267,177	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 267,177	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(7,086)	13
14	Non-Patient Meals	42	14
15	Telephone, Television and Radio	10,025	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,981	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	3,661	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,661	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,454,625	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,256,609	31
32	Health Care	3,148,600	32
33	General Administration	2,143,968	33
	B. Capital Expense		
34	Ownership	1,852,571	34
	C. Ancillary Expense		
35	Special Cost Centers	436,980	35
36	Provider Participation Fee	72,270	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,910,998	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,456,373)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,456,373)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.**
TAX RETURN NOT COMPLETED

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,169	1,538	$ 52,358	$ 34.04	1
2	Assistant Director of Nursing					2
3	Registered Nurses	26,479	34,788	866,614	24.91	3
4	Licensed Practical Nurses	12,325	16,216	387,145	23.87	4
5	Nurse Aides & Orderlies	104,792	148,712	1,316,797	8.85	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,352	1,408	30,362	21.56	9
10	Activity Assistants	15,326	16,747	192,509	11.50	10
11	Social Service Workers	2,852	3,057	82,908	27.12	11
12	Dietician	635	687	12,291	17.89	12
13	Food Service Supervisor	1,476	1,598	40,038	25.06	13
14	Head Cook	1,723	1,866	28,036	15.02	14
15	Cook Helpers/Assistants	4,264	4,619	42,388	9.18	15
16	Dishwashers	8,833	9,568	74,842	7.82	16
17	Maintenance Workers	4,440	4,609	103,207	22.39	17
18	Housekeepers	33,109	36,477	315,932	8.66	18
19	Laundry	11,518	12,675	81,001	6.39	19
20	Administrator	1,434	1,624	74,339	45.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	11,789	13,459	255,101	18.95	24
25	Vocational Instruction					25
26	Academic Instruction	1,763	1,877	43,082	22.95	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)	220	220	3,284	14.93	30
31	Medical Records	2,162	2,338	61,453	26.28	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	2,272	2,530	78,881	31.18	33
34	TOTAL (lines 1 - 33)	249,933	316,613	$ 4,142,568 *	$ 13.08	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,341	1-3	35
36	Medical Director	O	20,050	9-3	36
37	Medical Records Consultant	N	963	10-3	37
38	Nurse Consultant	T	1,045	10-3	38
39	Pharmacist Consultant	H	2,726	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	756	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 31,881		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	16	$ 744	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	16	$ 744		53

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JOAN BARRIS	ADMIN	0	$ 74,339
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 74,339

B. Administrative - Other

Description		Amount
ALEXANDER AND BLAKE	MANAGEMENT FEES	$ 379,200
TOTAL (agree to Schedule V, line 17, col. 3)		$ 379,200
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		161,301
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 161,301

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 164,612
Unemployment Compensation Insurance		45,045
FICA Taxes		317,951
Employee Health Insurance		241,137
Employee Meals		#REF!
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		3,072
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		0
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ #REF!

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	21,337
Health Care Worker Background Check	558
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	193,661
TRUST/FRANCHISE/CONTRIB/ETC	726
LICENSES & PERMITS	4,705
DUES & SUBSCRIPTIONS	934
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(726)
Less: Public Relations Expense	(0)
Non-allowable advertising	(186,600)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 34,595

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	6,043
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,043

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	PAVING PARKING LOT	2000	$ 4,800	3	$ 800	$ 1,600	$ 1,600	$ 800	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10	RELATED PARTY-LINCOLNSHIRE PROPERTIES:												
11	PAINTING/.REPAIRS	2003	30,206					5,034	10,069	10,069	5,034		
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 35,006		$ 800	$ 1,600	$ 1,600	$ 5,834	$ 10,069	$ 10,069	$ 5,034	$	$

Facility Name & ID Number THE WEALSHIRE # 0040956 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **46,695** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **72,270**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **#REF!** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees